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ABSTRACT

Anorexia nervosa and bulimia are currently being studied with great intensity by the medical profession. Anorexia nervosa was first described in the medical literature in 1868, but was considered a rarity until the late 1930's. Bulimia was not identified in the medical literature until 1979. Recent studies suggest that approximately five percent of the female teenage population experience anorexia nervosa. Although the nature of the illnesses prohibits the availability of reliable epidemiological data, it appears that eating disorders in all categories are increasing. The characteristics of eating disorders offer non-verbal signals to the problem long before clinical conditions are manifested. These signals include an obsession with thinness and a denial of feelings of hunger, satiety, fatigue, and physical pain. Clinical characteristics and indices of eating disorders are numerous. Clinical characteristics can be categorized under the headings of: (1) general/biological; (2) emotional/psychological; (3) familial; (4) social; and (5) physical symptoms. The goal of treatment for eating disorders is to return the body to a state of biological normalcy and to help the patient generate positive self-esteem. Educators should understand the complexity of anorexia nervosa and bulimia and be alert to their signals. Teachers can help students develop higher self-esteem, and home economics teachers and coaches can teach students about the energy values of food. Finally, educators should be prepared to refer students to support groups and physicians when needed. (NB)

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# ANOREXIA NERVOSA/BULIMIA: THE TEENAGER'S DILEMMA

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ANOREXIA NERVOSA/BULIMIA: THE TEENAGER'S DILEMMA

Abnormal food intake patterns, identified as anorexia nervosa, bulimia, bulimia nervosa, bulimarexia, compulsive eating jags, dietary chaos syndrome, stuffing syndrome, and counter regulation are being studied with greater intensity by members of the medical profession. Diagnosis is a clinical challenge since individuals, reputable in other behavior, tend to disguise their condition and then generate symptoms and complaints which will distract and mislead the medical practitioner. Criteria for diagnosis of several eating disorders have been published by the American Psychiatric Association; subgroups within each syndrome continue to appear. Behaviorally, eating disorders which are described by some as a self-created hell are characterized by intermittant cycles of starving, binging, and purging in the pursuit of thinness.

PREVALENCE

Anorexia nervosa was first described in the medical literature in 1868 by Sir William Gull of England. It was considered a rarity until the late 1930's when John Berkman of Mayo Clinic became aware of its prevalence in their patients. Between 1945 and 1975, 1781 patients were diagnosed as having anorexia nervosa. Ninety-one percent were female and nine percent were male. Other studies since that time indicate about the same ratio of female to male. Bulimia was not identified in the medical literature until 1979. Studies by Halmi of 539 college women in a summer session indicated that about five percent of the population were anorectic. A 1983 study by Johnson in a National Institute of Child Health and Human Development report revealed that one in every two hundred high school students aged 12-18 were anorectic; ninety percent were female and ten percent were male. A 1983 study (Szmukler) of English schoolgirls (1331, aged 14-18) revealed a prevalence of one in 120 or about five percent of that population.

Bulimia may accompany anorexia nervosa or it may occur independently. Halmi found two percent of the 539 college females in summer school to be bulimic. Szmukler found bulimia in one of 270 of the English schoolgirls. In a survey of 1268 adolescent girls in 1983, Johnson found that thirty-six percent were currently dieting; sixty-nine percent had dieted at some time in the past year; fifty-seven percent were binge eaters; sixteen percent purged after binging. In another 1983 survey by Pyle of 1355 college freshmen, 7.8% of the females were binging and purging as were 1.4% of the males. The prevalence of eating disorders as indicated in several studies is presented in Table I. As shown, approximately five percent of the female teenage population experience anorexia nervosa. More than two-thirds of the adolescent females report dieting at least one time for the purpose of losing weight within the past year. Over half of the adolescent girls admit to binge eating (consuming enormous amounts of food in a short period of time). As many as twenty percent of the adolescent females are controlling weight after binges by self-induced vomiting, laxatives, or diuretics. It appears that eating disorders in all categories are increasing; however, the nature of the illnesses prohibits the availability of reliable epidemiological data.

## CHARACTERISTICS

Anorexia nervosa: Individuals with anorexia nervosa or one of its subgroups exhibit many psychological and physiological characteristics. These disorders are primarily manifested by starvation with weight losses of as much as fifty percent or more of desirable body weight. Some anorectics restrict food intake in order to lose weight; others eat then purge either by vomiting, laxatives, or diuretics. The anorectic has a distorted perception of her body, rejects food, and is 15-50% underweight. Behavior is very regimented and individuals exhibit discipline and self-control. However, low self-esteem coupled with an initiating factor causes anxiety and the onset of an anorectic cycle

TABLE I. PREVALENCE OF ANOREXIA NERVOSA AND BULIMIA

| | Year | Subjects | Number | Mean Age | Female | Male |
|---|---|---|---|---|---|---|
| Anorexia Nervosa | 1945-75 | Mayo Clinic (Berkman) | 1751 | NA | 91% | 9% |
| | 1981 | College Women (Halmi) | 539 | NA | 5% of female population | |
| | 1983 | NICHHD (Johnson) | 1 of 200 | 12-18 | 90% | 10% |
| | 1983 | Schoolgirls (Sznukler) | 1331 | 14-18 | 5% of female population | |
| Bulimia | 1981 | College Women (Halmi) | 539 | NA | 2% of female population | |
| | 1983 | College Freshmen (Pyle) | 1355 | NA | 7.8% | 1.4% |
| | 1983 | Adolescent Girls (Johnson) | 1268 | 13-19 | 36% dieting<br>69% had dieted<br>57% binging<br>16% purging | |
| | 1983 | English Schoolgirls (Sznukler) | 1331 | 14-18 | 1 of 270 | |

from which there is no escape (Figure 1). The initiating factor in the cycle generally stems from an interruption of the status quo with examples drawn from physical, social, or personal environments. Initiating factors may include separation from family or friends by either death or distance, disruption of the family by divorce or marriage of a sibling, or a new environment such as relocation of the family or of the individual. Some initiating factors may be either real or imagined. Personal illness or situations which threaten esteem may initiate the cycle even if the situation is imagined. Fear of the cycle may also cause anxiety and thus be an initiating factor. Anxiety leads to hunger and deliberate fasting. The resultant low blood sugar causes mental confusion and depression; the cycle is perpetuated.

Bulimia: Bulimics characteristically binge on enormous amounts of food then purge to prevent weight gain. The bulimic has a normal perception of her body and is of normal weight; she reacts to anxiety by eating. The bulimic's lifestyle is regimented but lacking in self-control most of the time. The bulimic cycle (Figure 2) differs from the anorectic cycle in both the stimuli and the response to anxiety. A stressful event such as an exam, mealtime, disappointment, or the excitement of a prom, party, or date create anxiety. The bulimic responds by binging. Purging, an antic to relieve guilt and to prevent weight-gain, leads to depression and the cycle is perpetuated.

Low self-esteem and an inability to cope with anxiety are characteristic of both groups of eating disorders. Demographically both anorectics and bulimics are white, female, and upper or upper-middle class. They are intelligent, popular, respected, and perfectionists. The prognoses differ. There is a ten to fifteen percent fatality rate associated with anorexia nervosa; forty-nine percent recover or improve with therapy and forty percent experience no change in condition. There is a high recovery rate for bulimia with treatment

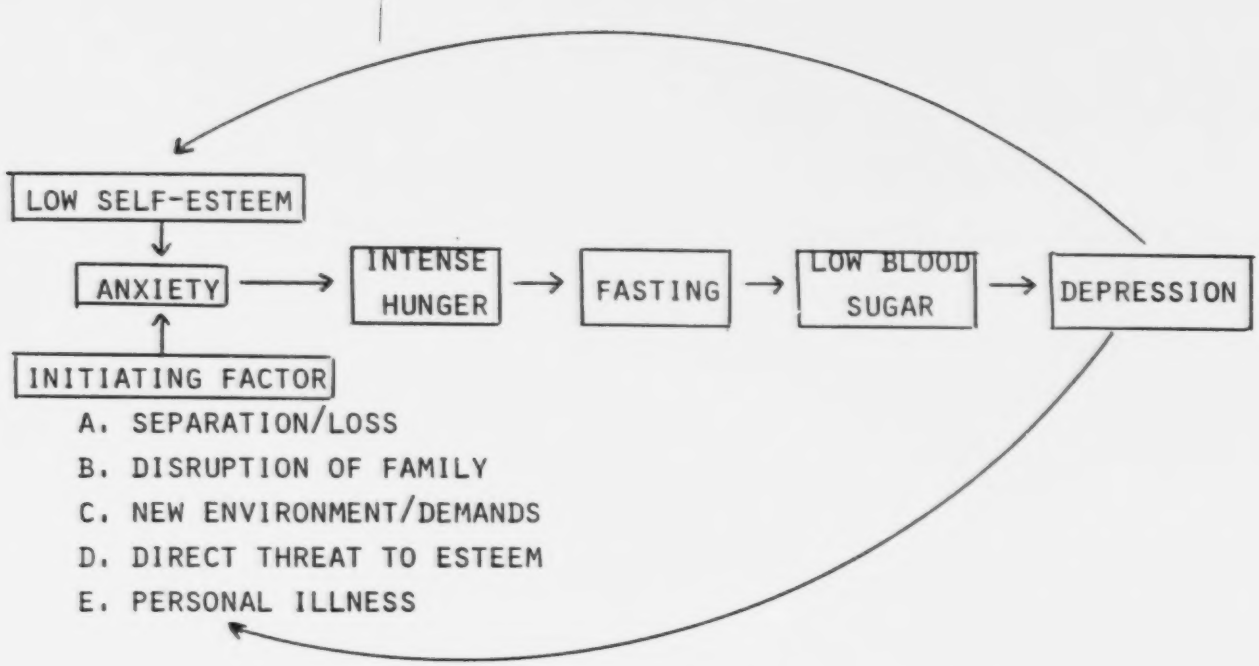


FIGURE I. THE ANORECTIC CYCLE

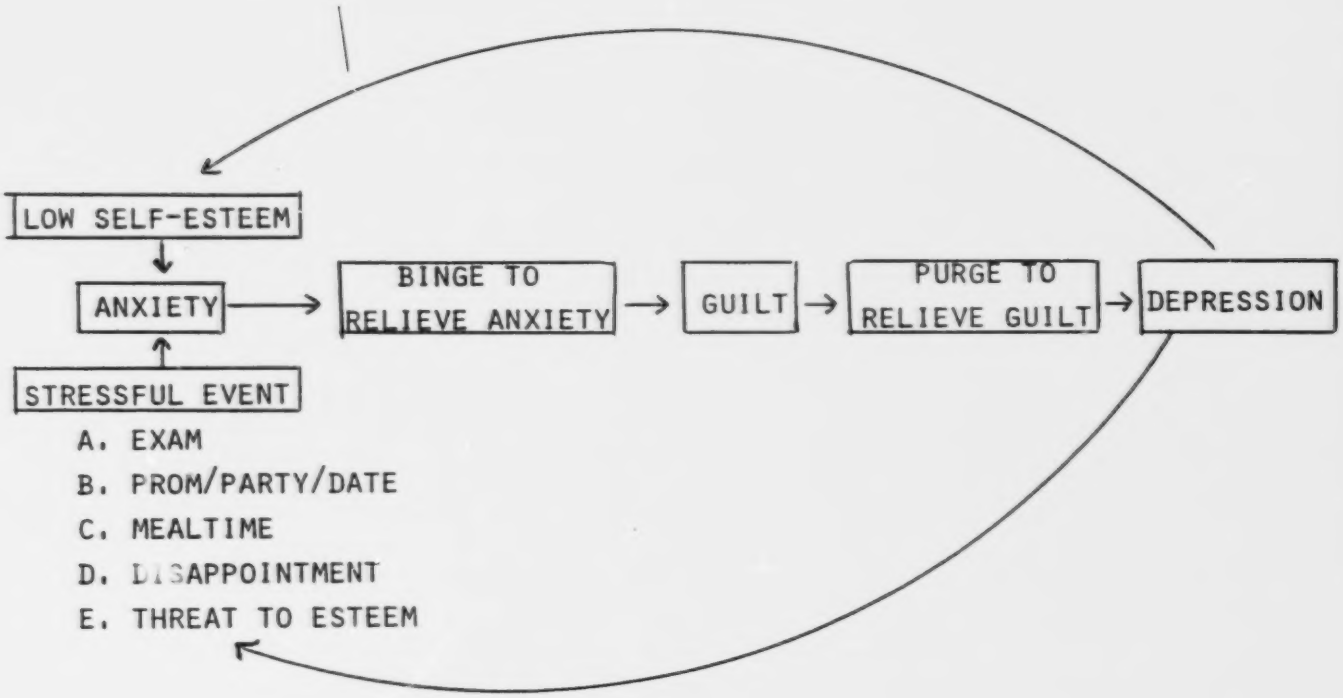


FIGURE 2, THE BULIMIC CYCLE

although the treatment frequently lasts for several years. Fatality from bulimia is associated with a higher-than-average suicide rate.

The characteristics of eating disorders offer non-verbal signals to the problem long before clinical conditions are manifested. There are obsessive desires for thinness with denial of feelings for hunger, satiety, fatigue, and physical pain. Some experience a grossly distorted image of physical size and appearance. Most are obsessed with dieting, activity, and regimentation. They do not respond well to suggestions or criticism; they prefer to function without interference. Both anorectics and bulimics are extremely competitive and make enormous efforts to be outstanding in almost everything they do. If asked, they deny that they have any problems.

Clinical characteristics and indices of eating disorders are numerous and may be loosely divided into several categories as shown on Table II. General/Biological: In addition to dissatisfaction with body size and pursuit of thinness, the anorectic has a fine body hair covering the face, arms, and torso. As anorexia progresses, body fat (adipose tissue) is depleted and muscle tissue is utilized for energy. Eventually the hyperactivity succumbs to apathy and immobility as basal metabolism adjusts to rates consistent with those observed in starvation. Feedback mechanisms help maintain the body's chemistry at relatively normal levels until starvation reaches its advanced stage. Both anorectics and bulimics experience a slow respiration rate, low heart rate, hypotension, hypothermia, hypoglycemia, constipation, sexual immaturity (absence of menses), and loss of water and electrolytes. Emotional/Psychological: Individuals with eating disorders have an extremely low self-esteem; they are unhappy and frequently depressed. Perfectionism and compulsiveness lead to tremendous anxiety. For the bulimic, the anxiety is further exaggerated by the fear of being discovered. Familial: Both anorectics and bulimics

TABLE II. CLINICAL CHARACTERISTICS OF ANORECTICS AND BULIMICS

GENERAL/BIOLOGICAL

- Dissatisfied with body
- Pursue thinness
- Fine body hair on face, arms, torso
- Slow respiration rate
- Low heart rate
- Hypotension (low blood pressure)
- Hypothermia (low body temperature)
- Constipated
- Deny hunger and pain
- Sexually immature (lack of menses)
- Upset body chemistry - water
  electrolytes

EMOTIONAL/PSYCHOLOGICAL

- Low self-esteem
- Unhappy
- Depressed
- Perfectionist
- Compulsive
- Anxious
- Fear of gaining weight (anorectic)
- Fear of maturation (anorectic)
- Fear of being discovered (bulimic)

FAMILIAL

- Dependent
- Parent/child conflict
- Lack of affection among family members
- Depressive illness in family
- Alcoholism in family

SOCIAL

- Shy (as a child)
- Non-social

PHYSICAL

- Hyperactive
- Athletic
- Overweight (as a child)
- Brittle hair and nails
- Peripheral edema

are overly dependent, usually on the female parent. There is frequently a father/daughter conflict and lack of affection among family members. In addition, any depressive illness or alcoholism in the family appears to be associated with the expression of anorexia or bulimia. Social: Those with eating disorders were generally shy as a child and tend to be non-social as a teenager. Physical: Individuals with either type of eating disorder tend to be hyperactive, athletic, and overweight as a child. They also present brittle hair and nails and peripheral edema. Economical: Due to a lowered resistence to infection, the anorectic incurs medical costs. The bulimic faces costly dental problems due to cavities created by the exposure of teeth to gastric secretions, primarily hydrochloric acid. The huge quantities of food the bulimic ingests during a binge frequently cost as much as $75.00 to $100.00 per binge; binges may occur daily.

## TREATMENT

The goal of treatment for eating disorders is to return the body to a state of biological normalcy and to help the individual generate a positive self-esteem. Therapy may be continued for a few months or several years before these goals are achieved. Most therapists are convinced that the solution to eating disorders lies in a person's life rather than in his/her behavior. Means of resolving stress and resolution of familial problems are apparently the most effective routes to recovery. Because of the bizzare expressions to eating disorders, those most likely to be confronted by students with eating disorders are home economics teachers and coaches. These professionals have an understanding and knowledge of energy intake and expenditure which are obsessions for the student with anorexia and/or bulimia. Since persons with either type of disorder have an intense fear of being discovered and families usually are unaware or refuse to believe the child's dilemma, students frequently turn to a role model in the classroom for support of their unusual energy interests.

## THE ROLE OF EDUCATORS

Educators should understand the complexity of anorexia nervosa and bulimia and be alert to their non-verbal signals: the pursuit of thinness, perfectionism, hyperactivity, and other characteristics identified in Table II. While guiding students in the pursuit of educational goals, educators can help students learn to feel good about themselves. Teachers can also incorporate means for recognizing, avoiding, and reducing stress in classroom activities. Home economics teachers and coaches have the expertise to provide students with the requested information on energy values of food and energy used in activities. Simultaneously, the student must be given the facts regarding the need for energy for all body functions and made aware of damage to tissue such as brain and liver in its absence. Students should understand that fun foods (usually high in carbohydrate) are not bad foods when consumed in moderation. Finally, educators should be prepared to help students access support groups in hospitals and clinics and to identify for students those physicians who will work with anorectics and/or bulimics.

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